Offer women with triplet pregnancies a first trimester ultrasound scan between 11 weeks 0 days and 13 weeks 6 days to estimate gestational age, determine chorionicity and screen for fetal trisomies (ideally, these should all be performed at the same scan).

Assign nomenclature to babies in triplet pregnancy and document this clearly in the woman’s notes to ensure consistency throughout pregnancy.

Use the largest baby to estimate gestational age to avoid the risk of estimating it from a baby with early growth pathology.

Determine chorionicity at the time of detecting the triplet pregnancy by ultrasound using the number of placental masses, the lambda or T-sign and membrane thickness.

If the woman presents after 14 weeks 0 days, determine chorionicity at the earliest opportunity by ultrasound using all of the following: the number of placental masses, the lambda or T-sign, membrane thickness and discordant fetal sex.

If transabdominal ultrasound scan views are poor because of a retroverted uterus or a high body mass index, use a transvaginal ultrasound scan to determine chorionicity.

If it is not possible to determine chorionicity by ultrasound at the time of detecting the triplet pregnancy, seek a second opinion from a senior ultrasonographer. If chorionicity cannot be determined even after referral, manage as monochorionic pregnancy until proved otherwise.

Give the same advice about nutritional supplements, diet and lifestyle as in routine antenatal care.

Be aware of the higher incidence of anaemia in women with triplet pregnancies compared to single pregnancies.

Clinical care:

Clinical care for women with triplet pregnancies should be provided by a nominated multidisciplinary team consisting of:

- a core team of named specialist obstetricians, specialist midwives and ultrasonographers, all of whom have experience and knowledge of managing triplet pregnancies
- an enhanced team for referrals, which should include a perinatal mental health professional, a women’s health physiotherapist, an infant feeding coordinator and a dietitian.

Members of the enhanced team should have experience and knowledge relevant to triplet pregnancies.

Coordinate clinical care for women with triplet pregnancies to minimise the number of hospital visits, provide care as close to the woman’s home as possible and provide continuity of care within and between hospitals and the community.

Seek a consultant opinion from a tertiary level fetal medicine centre for:

- monochorionic monoamniotic triplet pregnancies
- monochorionic diamniotic triplet pregnancies
- dichorionic diamniotic triplet pregnancies
- pregnancies complicated by any of the following:
  - discordant fetal growth
  - fetal anomaly
  - discordant fetal death
  - feto-fetal transfusion syndrome.

Regional networks should agree care pathways for managing all triplet pregnancies to ensure that each woman has a care plan in place that is appropriate for the chorionicity of her pregnancy.

The core team should offer information and support specific to triplet pregnancies at the first contact with the woman and provide ongoing opportunities for further discussion and advice covering:

- antenatal and postnatal mental health and wellbeing
- antenatal nutrition
- the risks, symptoms and signs of preterm labour, the potential need for corticosteroids for fetal lung maturation
- likely timing and possible modes of delivery
- breastfeeding
- parenting
- the different options for screening (as in routine antenatal care)
- the risks associated with triplet pregnancies for women and babies:
  - hypertensive disorders
  - feto-fetal transfusion syndrome in monochorionic and dichorionic triplet pregnancies
  - fetal abnormalities
  - chromosomal abnormalities (fetal trisomies)
  - the higher false positive rate of screening tests in triplet pregnancies
  - the increased likelihood of being offered invasive testing in triplet pregnancies
- the physical risks and psychological implications related to selective fetal reduction.

A healthcare professional with experience of caring for women with triplet pregnancies should offer information and counselling to women before and after every screening test.

Explain sensitively the aims and possible outcomes of all screening and diagnostic tests to minimise anxiety.

Discuss with women with triplet pregnancies the timing of birth and possible modes of delivery early in the third trimester.

Decide if the pregnancy is dichorionic diamniotic (DD), monochorionic diamniotic (DM), or monochorionic monoamniotic (MM).
Trichorionic triamniotic triplet pregnancies

**Screening and management** Inform women about the complexity of decisions they may need to make depending on the outcomes of screening, including different options according to the chorionicity of the pregnancy.

- Identify chromosomal abnormalities
  - Healthcare professionals who screen for fetal trisomies should:
    - map the fetal positions
    - use nuchal translucency and maternal age to screen for fetal trisomies between 11 weeks 0 days and 13 weeks 6 days in triplet pregnancies
    - calculate the risk of fetal trisomies in each fetus.
  - Do not use second trimester serum screening for fetal trisomies in triplet pregnancies.
  - Offer women with triplet pregnancies who have a high risk of trisomy 21 (Down’s syndrome) (use a threshold of 1:150 as defined by FASP) referral to a fetal medicine specialist in a tertiary level fetal medicine centre.

- Identify structural abnormalities
  - Offer screening for structural abnormalities (such as cardiac abnormalities) as in routine antenatal care.
  - Consider scheduling ultrasound scans in triplet pregnancies at a slightly later gestational age than in single pregnancies and be aware that the scans will take longer to perform.
  - Allow 45 minutes for the anomaly scan (as recommended by FASP).
  - Allow 30 minutes for growth scans.

- Pregnancy complications
  - Measure blood pressure and test urine for proteinuria to screen for hypertensive disorders at each antenatal appointment in triplet pregnancies as routine antenatal care guideline.
  - Advise women that they should take 75 mg of aspirin daily from 12 weeks until the birth of the babies if they have risk factors for hypertension.
  - Perform a full blood count at 20-24 weeks to identify women who need early supplementation with iron or folic acid, and repeat at 28 weeks as in routine antenatal care.

- Risks of spontaneous preterm delivery
  - Inform women with triplet pregnancies that about 75% of triplet pregnancies result in spontaneous birth before 35 weeks 0 days.
  - Inform women of their increased risk of preterm birth and about the benefits of targeted corticosteroids. Also inform them that there is no benefit in using untargeted (routine) corticosteroids.
  - Do not use fetal fibronectin testing alone to predict risk of spontaneous preterm birth.
  - Do not use home uterine activity monitoring to predict risk of spontaneous preterm birth.
  - Do not use cervical length (with or without fetal fibronectin) routinely to predict the risk of spontaneous preterm birth.

Offer women with uncomplicated pregnancies appointments with a healthcare professional from the core team as indicated in Box 1.
Screening for intrauterine growth restriction

Do not use abdominal palpation or symphysi-fundal height measurements to predict intrauterine growth restriction.

Estimate fetal weight discordance using two or more biometric parameters at each ultrasound scan from 20 weeks. Aim to undertake scans at intervals of less than 28 days. Consider a 25% or greater difference in size between triplets as a clinically important indicator of intrauterine growth restriction and offer referral to a tertiary level fetal medicine centre.

Do not use umbilical artery Doppler ultrasound to screen for intrauterine growth restriction or birthweight differences.

Seek a consultant opinion from a tertiary level fetal medicine centre for:
- discordant fetal growth
- fetal anomaly
- discordant fetal death

Timing of birth

Inform women that spontaneous preterm birth and elective preterm birth are associated with an increased risk of admission to a special care baby unit.

Inform women that continuing uncomplicated triplet pregnancies beyond 36 weeks 0 days increases the risk of fetal death.

Offer women with uncomplicated pregnancies elective birth from 35 weeks 0 days, after a course of antenatal corticosteroids has been offered.

For women who decline elective birth, offer weekly appointments with the specialist obstetrician. At each appointment offer an ultrasound scan, and perform weekly biophysical profile assessments and fortnightly fetal growth scans.

Do not use the following interventions (alone or in combination) routinely to prevent spontaneous preterm birth:
- bed rest at home or in hospital
- intramuscular or vaginal progesterone
- cervical cerclage
- oral tocolytics.

Do not use single or multiple untargeted (routine) courses of corticosteroids.
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- **Identify feto-fetal transfusion syndrome (FFTS)**
  - Do not screen for FFTS in the first trimester.
  - Start diagnostic monitoring with ultrasound for FFTS (including to identify membrane folding) from 16 weeks. Repeat monitoring fortnightly until 24 weeks.
  - Carry out weekly monitoring of triplet pregnancies with membrane folding or other possible early signs of feto-fetal transfusion syndrome (specifically, pregnancies with intertwin membrane infolding and amniotic fluid discordance) to allow time to intervene if needed.

- **Identify structural abnormalities**
  - Offer screening for structural abnormalities (such as cardiac abnormalities) as in routine antenatal care.
  - Consider scheduling ultrasound scans in triplet pregnancies at a slightly later gestational age than in single pregnancies and be aware that the scans will take longer to perform.
  - Allow 45 minutes for the anomaly scan (as recommended by FASP).
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**Seek a consultant opinion from a tertiary level fetal medicine centre for:**
- discordant fetal growth
- fetal anomaly
- discordant fetal death
- FFTS.
<table>
<thead>
<tr>
<th>Type of triplet pregnancy</th>
<th>Timing of antenatal appointments with a healthcare professional from the core team</th>
<th>Timing of ultrasound scans</th>
<th>Minimum number of contacts with a specialist obstetrician</th>
<th>Minimum total number of antenatal appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monochorionic triamniotic</td>
<td>11 weeks 0 days to 13 weeks 6 days, 16, 18, 20, 22, 24, 26, 28, 30, 32 and 34 weeks</td>
<td>At each antenatal appointment (see left)</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Dichorionic triamniotic</td>
<td>11 weeks 0 days to 13 weeks 6 days, 16, 18, 20, 22, 24, 26, 28, 30, 32 and 34 weeks</td>
<td>At each antenatal appointment (see left)</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Trichorionic triamniotic</td>
<td>11 weeks 0 days to 13 weeks 6 days, 16, 20, 24, 28, 32 and 34 weeks</td>
<td>11 weeks 0 days to 13 weeks 6 days, 20, 24, 28, 32 and 34 weeks</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Women with pregnancies involving a shared amnion should be offered individualised care from healthcare professionals with expertise in this area.